Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Rural Health Care Universal Service	)	WC Docket No. 02-60
Support Mechanism	)	

REPLY COMMENTS OF THE NATIONAL ASSOCIATION OF TELECOMMUNICATIONS OFFICERS AND ADVISORS AND THE NATIONAL ASSOCIATION OF COUNTIES

The National Association of Telecommunications Officers and Advisors ("NATOA")[1] and the National Association of Counties ("NACo")[2] (collectively, "Commenters") respectfully submit these reply comments in response to the Federal Communications Commission's Notice of Proposed Rulemaking ("NPRM"), FCC 10-125, released August 9, 2010. In an effort to expand the use of broadband to improve

[1] The National Association of Telecommunications Officers and Advisors (NATOA) is the national association that represents the communications needs and interests of local governments, and those who advise local governments. NATOA's membership includes local government officials and staff members from across the nation whose responsibility is to advise and implement telecommunications policy for the nation's local governments. These responsibilities range from cable franchising, rights-of-way management and government access programming to information technologies and Institutional Network (INet) planning and management. For more information about NATOA, visit www.natoa.org.

[2] The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, celebrating its 75th Anniversary in 2010, NACo provides essential services to the nation's 3,068 counties. NACo advances issues with a unified voice before the federal government, improves the public's understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACo, visit *www.naco.org.*

the quality and delivery of health care, the Commission voted to invest $400 million annually from the Universal Service Fund to help finance connectivity in communities where broadband services are currently unavailable or insufficient. As a result, the Commission now seeks comment on three proposed major changes to the rural health care initiative: 1) the creation of a health infrastructure program that would support up to 85% of the construction costs of new or updated regional or statewide broadband networks for health care purposes; 2) the establishment of a broadband services assess program that would subsidize 50% of the monthly recurring costs for eligible public or non-profit rural health care providers; and 3) to expand the definition of "eligible health care provider" to include data centers, skilled nursing facilities, and renal dialysis centers**.**

INTRODUCTION

Local governments have long advocated for increased availability of affordable broadband to all parts of the country. It is a fact that the deployment and adoption of advanced communications services leads to, among other things, increased economic development, job creation, and global competitiveness. Further, through the use of such services as telemedicine and distance learning, the quality of life for all Americans – regardless of where they live – can be improved.

But while the public and private sectors should justifiably take pride in the great accomplishments achieved to date, more must be done. This is especially true in the more rural and sparsely populated areas of our country. According to the Commission's Sixth Broadband Deployment Report, nearly one-third of the nation's counties lack access to broadband. These "unserved" counties, on average, have populations under

25,000, with a population density of just over 138 people per square mile. This compares with an average national county population of nearly 95,500 and a population density of approximately 283 people per square mile.[3]

It is these "unserved" counties that could benefit the most from advanced broadband services, such as telemedicine. Indeed, up to 30% of rural health clinics do not have adequate broadband technology that can be used to provide remote diagnostics and medical monitoring to patients living in the most isolated areas of our country. For example, the lack of broadband is a major problem in New Hampshire's northern counties. Because of limited service, it is nearly impossible for these counties to pursue inter/intra-facility health information systems. Furthermore, this lack of service adversely impacts emergency preparedness activities.[4]

With these thoughts in mind, we offer the following comments.

A. Creation of a Health Infrastructure Program

Commenters are concerned with the Commission's admission that, despite its previous efforts, many health care providers, especially in rural areas and on Tribal lands, remain under-connected. One reason for this lack of service is that many health providers cannot access certain telemedicine services due to existing broadband connectivity gaps in service, especially among small, rural providers. Further, as explained in the National Broadband Plan ("NBP"), larger physician offices, clinics and

[3] We are aware of the fact that, by adopting the minimum speed threshold proposed in the National Broadband Plan of actual download speeds of at least 4 Mbps and actual upload speeds of at least 1 Mbps, the report captured more counties falling into the "unserved" category. Furthermore, we agree with the adoption of the *de minimis* threshold that at least one percent of the households in a county must subscribe to broadband before a finding may be made that broadband is "available" in a particular jurisdiction.

[4] *See Comments of Advanced Regional Communications Cooperative on Behalf of Clarion Hospital, Clarion, Pennsylvania,* WC Docket No. 02-60, filed August 16, 2010.

hospitals also face connectivity problems because their size and health IT needs require dedicated Internet access ("DIA") solutions and cannot use mass-market broadband. For this reason, we are supportive of the creation of a health infrastructure program that will provide financial support for the construction of new or updated regional or statewide broadband networks.

1. 85% Subsidy

The Commission proposes that the program would fund to up 85% of the eligible costs for the design, construction, and deployment of dedicated broadband networks in areas of the country where existing broadband infrastructure is inadequate. Funding would be through a streamlined application and selection process. For instance, the Commission proposes, and we support, the use of a user-friendly online application. We also support the concept that applications submitted for funding be publicly available on the Universal Service Administration Company's website.

Commenters, however, are concerned that even with the 85% funding subsidy, many small rural hospitals and clinics will have a difficult time raising the 15% cash match. We agree with the Arizona Rural Health Office that the Commission consider modifying the 15% cash match to permit in-kind contributions.[5]

2. Build-out

While the Commission proposes a five-year build-out period, there may be conditions beyond the control of the applicant to complete the project within that given timeframe. For example, inclement weather in many rural areas of the country may very well wreak havoc on even the most aggressive construction schedules. On the

[5] See *Comments of the Arizona Rural Health Office,* WC Docket No. 02-60, filed September 8, 2010; *Comments of the Oregon Health Network and the Telehealth Alliance of Oregon,* WC Docket No. 02-60, filed September 8, 2010.

other hand, some projects may be able to be completed in a much shorter timeframe, which could save resources to fund other projects. Commenters support the use of construction benchmarks and reporting requirements to ensure approved projects progress at a reasonable pace.

3. Speed

Because the focus of the health infrastructure program is on the funding of dedicated networks and not on the use of existing mass-market solutions, Commenters believe that the Commission's proposal to establish, at a minimum, a connectivity speed of 10 Mbps is appropriate – assuming such speed is capable of handling current and future healthcare applications. While a minimum threshold may negatively affect some jurisdictions and prevent the funding of a proposed system, we believe that limited federal funds should be invested in the networks that will provide the biggest bang for the buck and be able to handle the new health care applications as they become available. Indeed, any minimum threshold established by the Commission should provide for a robust network capable of handling a number of various applications and supporting future economic growth. Indeed, any network constructed should be capable of cost-effectively scaling up in speed as the technologies become more affordable, ensuring that the investment in these networks is "future-proof".

4. Lack of Service Providers

Time and again we have seen that private investment in broadband infrastructure may be limited in less densely populated areas where build-out costs may be high and return on investment is low. As a result, it makes sense, when federal funding is limited, to target funds where existing broadband infrastructure is insufficient to handle the

needs of health IT. However, we are concerned that the Commission's various proposals to require applicants to show broadband unavailability or insufficiency may pose an expensive, procedural impediment to many jurisdictions. Rather, we propose that since applications will be posted online and available for public viewing, no formal survey or report be required unless a local service provider objects to the entity's declaration that there is no existing broadband service or that the current system is insufficient to manage a dedicated health care network. In addition, in the case of an objection raised by an operator, we propose that no formal report or survey of service availability be required in the event the entity can show that it did not receive any proposals from qualified network vendors substantially meeting the terms of the requested services within one-year prior to the date of application.

5. Consortium Applications

We support the concept that consortium applications be permitted and that such applications include letters of agency from each participating party. Due to cost restraints, the only way many rural health care providers may be able to apply for funding will be through joining a network or consortium of eligible health care providers. Also, the fact that the individual members may be funded by an ineligible health care provider, such as a state or local government entity or some other non-profit entity, should not be a disqualifying factor. Consortium funding is an effective way to leverage public funds to bring broadband service to adjoining communities and to avoid the construction of redundant networks.

6. Funding Caps

Funding caps may be a way to ensure that multiple projects in various geographic areas of the country will receive funding. However, such caps may act to deter more expensive, but just as vital, projects in areas with higher construction costs due to topography, and so on. Indeed, it may be these very reasons why private industry is not currently servicing these areas. While the Commission notes that it retains the discretion to grant exceptions to the cap on a case-by-case basis, we recommend that the Commission put into place an expedited waiver process to encourage these projects to apply for funding in a timely manner.

7. Excess Capacity

Because of the very nature of the networks to be deployed, excess capacity will – or should – necessarily be built into the project. However, as the Commission points out, it is imperative that the underlying purpose of the network – a dedicated health care network – be preserved Further, because of the use of taxpayer dollars to pay for the system, it is important that these funds not be used to subsidize unauthorized uses and steps should be taken to prevent waste, fraud, and abuse. But we need to recognize that funding could be better utilized if services can be made available to anchor institutions, schools, libraries, and other local government facilities.

In determining what non-eligible entities should be permitted to use the network, we propose a rebuttable presumption that any local government entity is eligible to use the network, especially since a majority provides public health services. Local government entities should also be permitted to use the network to deal with public safety concerns.

Just as rural communities have problems accessing services capable of handling health care IT, these same communities have problems with access to a truly interoperable public safety network. Here is the perfect opportunity to potentially leverage various public funding sources for the purpose of building and maintaining a broadband network that can support both telemedicine and public safety communications needs.

Furthermore, we are supportive of permitting the use of excess capacity for schools and libraries, anchor institutions, and other appropriate local non-profits. Also, these services should be made available to county jails and other detention facilities for health care purposes.

Permitting shared networks will promote efficiencies, result in lower costs for all users, and help lessen the "siloing-effect" of dedicated networks.

B. Financial Support for Monthly Recurring and Limited Non-Recurring Costs of Broadband Services

Commenters are supportive of the Commission's proposal to provide up to 50% of monthly recurring costs, and selected non-recurring costs, of broadband service for eligible providers. We are especially supportive of the Commission's position that, at least for the infrastructure program, reasonable administrative expenses would be eligible for some support. Reviewing bids, working with vendors, and so on is costly. By suggesting that some of these costs would be eligible for funding after selection based on the initial application would allow those communities with very limited resources to proceed with planning and designing of networks.

However, we are concerned, as stated above, that some jurisdictions most in need of broadband services will be unable to afford the monthly recurring and limited non-recurring costs, even with the 50% subsidy. We encourage the Commission to consider establishing a higher rate.

C. Expanding the Definition of "Eligible Health Care Provider"

Commenters are supportive of the Commission's proposal to expand the definition of "eligible health care provider" to include skilled nursing facilities, renal dialysis centers, and others. We also support expanding the definition to include emergency medical services, a position echoed by many public safety organizations.[6] The goal of increased broadband deployment and adoption of health care IT is two-fold: to make services more readily available and to lower the cost of those services. We believe that broadening this definition will help achieve those twin goals.

As pointed out by the Commission, the delivery of health care in America is evolving and as traditional acute care facilities have declined in number, skilled nursing facilities have stepped in to fill the void. Because of advances in telemedicine, some patients can be treated effectively and efficiently outside the traditional hospital setting. As a result, these facilities, and the important health care services they provide, must fall within an expended definition of "eligible health care provider." Furthermore, it is imperative that the Commission recognize that the definition remain flexible in order to capture new and evolving health care services.

[6] *Reply Comments of the National Sheriff's Association,* WC Docket No. 02-60, filed September 15, 2010.

CONCLUSION

We applaud the Commission for its efforts to expand broadband services to all parts of our country, and especially its focus on providing high-speed access to rural health care providers.

Respectfully submitted,

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